Social Security Administration

1967 AMENDMENTS
CHART BOOKLET

MEDICARE

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
JANUARY 1968

IMPORTANT NOTICE

The interpretations contained herein are preliminary, and subject to further refinement or revision. This is not an instructional, procedural or public information issuance, and should be used only for training purposes by intermediaries, carriers, providers, and other components of the medicare program.

The Table of Contents in this booklet begins with Chart Number 37. Charts 1 through 36 deal with the retirement, survivors and disability provisions of the social security law that were changed by the 1967 amendments. Therefore, they have not been included in this booklet, which will deal with the medicare portion of the 1967 amendments only.

SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEALTH INSURANCE

1967 AMENDMENTS CHART BOOKLET
MEDICARE
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Effective: 1/2/68 (The Date of Enactment)

METHODS OF SMI PAYMENT

- ASSIGNMENT TAKEN
  Carrier pays physician and supplier
- NO ASSIGNMENT--(bill paid or unpaid)
  Carrier pays patient on basis of itemized claim (Form 1490)

CHART NO. 37

METHODS OF SMI PAYMENT

Medical insurance payments for physicians' and other medical services may now be made directly to the patient on the basis of an itemized bill—even though it has not been paid. There is no change in the assignment method under which physicians and suppliers may have payment made directly to them.

There are thus two ways in which medical insurance claims are handled. One is for the physician to take an assignment and collect the medicare payment from the carrier. (If he agrees to do so, he accepts the reasonable charge, as determined by the medicare carrier, as his full charge.)

The second way is for the patient to apply for the payment. Under the old law, if the physician did not take an assignment, the patient had to pay him before reimbursement could be made. Now the patient need only get an *itemized* bill (paid or unpaid) and send it in with his request for payment. If the physician's office will fill in part II of the Request for Medicare Payment (SSA–1490), this serves as an itemized bill.

Q. What incentive is there for the physician to use the assignment method?

A. Under the assignment method the physician is guaranteed payment of 80 percent of the reasonable charges, after the $50 deductible is met. However, if there is no assignment, payment will go directly to the beneficiary and the physician can use normal collection procedures for the entire fee.

Q. What about claims pending at the time of enactment?

A. The new provision applies to all bills received or processed by carriers on or after January 2, 1968 (the date of enactment) even though the services were rendered before that date.

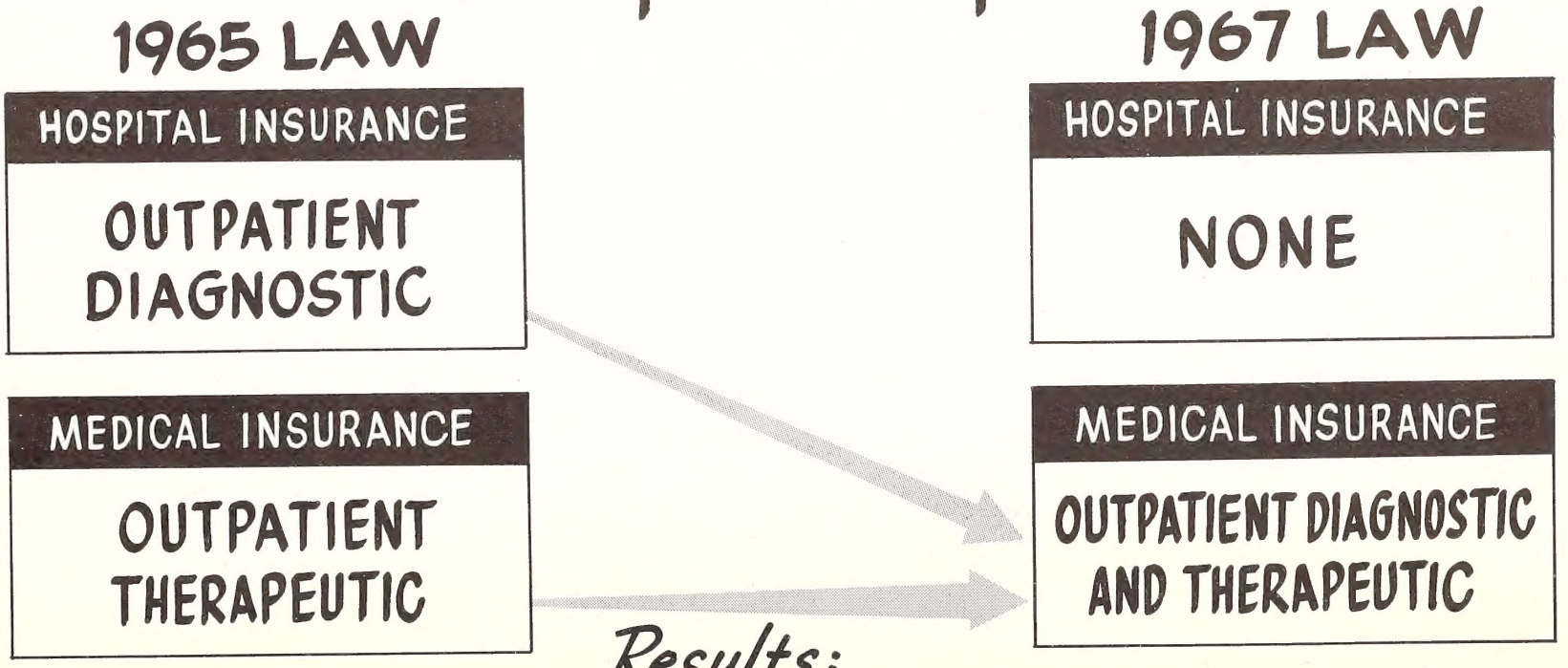
Q. Will the Request for Medicare Payment (SSA–1490) be revised?

A. Yes, but the present 1490 may continue to be used for both payment methods.

HI ADMINISTRATIVE SIMPLIFICATION

Effective: 4/1/68

Consolidation of Outpatient Hospital Services under SMI



Results:

- FEWER ADMINISTRATIVE DIFFICULTIES-
  SUBJECT TO ONE DEDUCTIBLE AND COINSURANCE
- BETTER BENEFICIARY UNDERSTANDING

CHART NO. 38

CONSOLIDATION OF OUTPATIENT HOSPITAL SERVICES UNDER SMI

The 1965 law provided that outpatient hospital services *diagnostic* in nature (performed to determine the nature and extent of an injury or illness) were covered by the hospital insurance program. Those services *therapeutic* in nature (performed as a treatment to heal or cure an injury or illness) were covered by the medical insurance program. Diagnostic services were subject to a $20 deductible for each 20-day study and a 20% coinsurance for expenses above the deductible. The regular annual SMI $50 deductible and 20% coinsurance were applicable to the therapeutic services. Finally, the $20 "diagnostic" deductible was considered a covered expense under the medical insuranc program. Because of these provisions—the different deductibles, the separate coverage requiring separate billing, and the transfer of the diagnostic deductible—hospitals and beneficiaries experienced recordkeeping difficulties and confusion.

Effective 4/1/68, hospital outpatient diagnostic services are covered by the medical insurance program rather than by the hospital insurance program. Benefits are based on 80% of the hospital's reasonable cost after the patient has met the $50 annual SMI deductible. The patient is responsible only for the annual $50 deductible and 20% coinsurance.

This provision simplifies the reimbursement procedure for services furnished hospital outpatients and facilitates beneficiary understanding. It makes the payments subject to a single set of rules for determining patient eligibility, patient and medicare liability, and trust fund accountability. It removes the possibility that the amount of benefits payable for diagnostic services in a physician's office might be different from the amount payable for the same tests with identical charges conducted in a hospital outpatient department. Moreover, since all hospital services furnished to outpatients and related services of hospital-based physicians are covered under SMI combined billing (where the hopital bill includes the physicians' fees as well as hospital costs) is possible where this type of billing is the usual practice of the hospital and physicians.

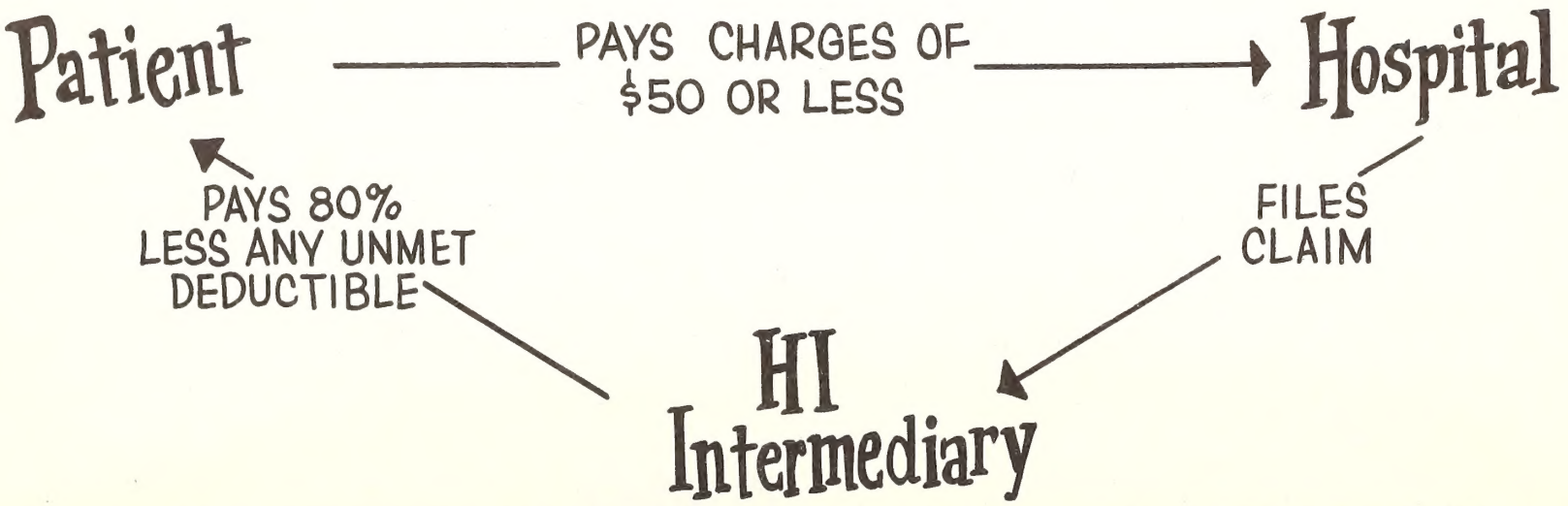
In combined billing cases, the HI intermediary can make all the required payments to the hospital at one time (drawing from SMI funds). Of course, no hospital-based physician is required to use the combined billing method; he can bill the patient directly if he prefers.

HI ADMINISTRATIVE SIMPLIFICATION

Effective: 4/1/68

REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

ALTERNATIVE METHOD AVAILABLE*



REIMBURSEMENT TO HOSPITAL IS ADJUSTED TO COST BASIS

* In particular circumstances permitted by SSA regulations

CHART NO. 39

SIMPLIFIED REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

Effective for services furnished after March 31, 1968, hospitals may, in situations which will be described in Social Security Administration regulations, collect an outpatient charge of $50 or less from the beneficiary. In such cases, the beneficiary would receive payment for 80% of the charges above any unmet deductible as medical insurance reimbursement on the basis of a claim prepared on his behalf by the hospital. This provision will simplify hospital collection processes where the patient can pay small outpatient bills at the time services are rendered and the status of the deductible cannot be immediately ascertained. Payments to the hospital will be annually adjusted to assure that total hospital reimbursement for outpatient services does not exceed what the hospital would have received if it had submitted all bills on a cost reimbursement basis.

HI ADMINISTRATIVE SIMPLIFICATION

Effective: 4/1/68

SIMPLIFIED REIMBURSEMENT FOR RADIOLOGY & PATHOLOGY

- NO DEDUCTIBLE OR COINSURANCE FOR:

  Radiology and Pathology Services Rendered to Hospital Inpatients by Physicians in the Fields of Radiology and Pathology

- PERMITS COMBINED BILLING FOR HOSPITAL AND PHYSICIANS' SERVICES.

CHART NO. 40

SIMPLIFIED REIMBURSEMENT FOR RADIOLOGY AND PATHOLOGY

Effective 4/1/68, payment of the full reasonable charges may be made under medical insurance for radiology and pathology services furnished by physicians to inpatients of participating hospitals. The $50 annual deductible does not have to be met. Thus, because there will rarely be any patient liability for these services, medicare reimbursement procedures can be greatly facilitated and the patient can frequently be left out of the process completely.

Under this provision, it will also be possible to pay for radiology and pathology services to hospital inpatients in a manner that is more consistent with the usual billing procedures of many hospitals and the manner in which these services are reimbursed by most other health insurance programs. Where the hospital customarily bills for both the hospital's services and the services of the pathologists and radiologists, the absence of the medical insurance deductible and coinsurance will now make it unnecessary to break down the bill on a patient-by-patient basis into the parts covered under the hospital insurance and medical insurance programs, since this can be done on an aggregate basis. Thus, where the total services are billed through the hospital, the provision would provide opportunities for the development of hospital billing procedures that will greatly reduce paperwork and facilitate administration.

HI ADMINISTRATIVE SIMPLIFICATION

Effective: 1/2/68 (The Date of Enactment)

SOME PHYSICIAN CERTIFICATIONS ELIMINATED

Eliminated- CERTIFICATION OF MEDICAL NEED FOR:

- Admissions to General Hospitals
- Outpatient Hospital Services

Retained - CERTIFICATION OF MEDICAL NEED FOR:

- Psychiatric & TB Hospital Services
- ECF & HHA Services
- Inpatient Hospital Services Furnished over a Period of Time

CHART NO. 41

SOME PHYSICIAN CERTIFICATIONS ELIMINATED

Under the 1965 law, payments for covered provider services were made only if a physician certified (by a signed statement) that in each case the services were medically necessary. When these services were prescribed over a period of time, a physician had to recertify to the continuing need for these services.

The present law eliminates the requirement that there be a physician's certification as to the need for admission to general hospitals. It also eliminates the outpatient hospital services certification requirement.

These changes do not alter the basic concept that medicare reimbursement will be made for only medically necessary covered items and services. They do, however, recognize that outpatient hospital services and admissions to general hospitals are almost always medically necessary and that the written certification of this fact resulted in largely unnecessary paperwork.

Physician certification is retained for payment of services by psychiatric and tuberculosis hospitals, extended care facilities and home health agencies. These certifications are important and meaningful because special conditions (such as prior hospitalization) are attached to payment for services furnished by these providers. The requirement for physician certifications after inpatient hospital services have been furnished over a period of time is also retained.

Q. When must certification *after* admission to a general hospital be made?

A. Certification is required as of the 14th day of hospitalization, the first recertification no later than the 21st day, and subsequent recertifications at intervals established by the utilization review committee, not to exceed 30 days.

Q. Is any particular form required?

A. As before, no particular form must be used; the individual hospital decides the format of the statement and how it is to be obtained. The statement must give the reasons for continued hospitalization, the estimated time of further stay, and plans, where appropriate, for post-hospital care.

HI HOSPITAL INSURANCE BENEFIT

Effective: 1/1/68

ADDITIONAL DAYS OF HOSPITAL COVERAGE

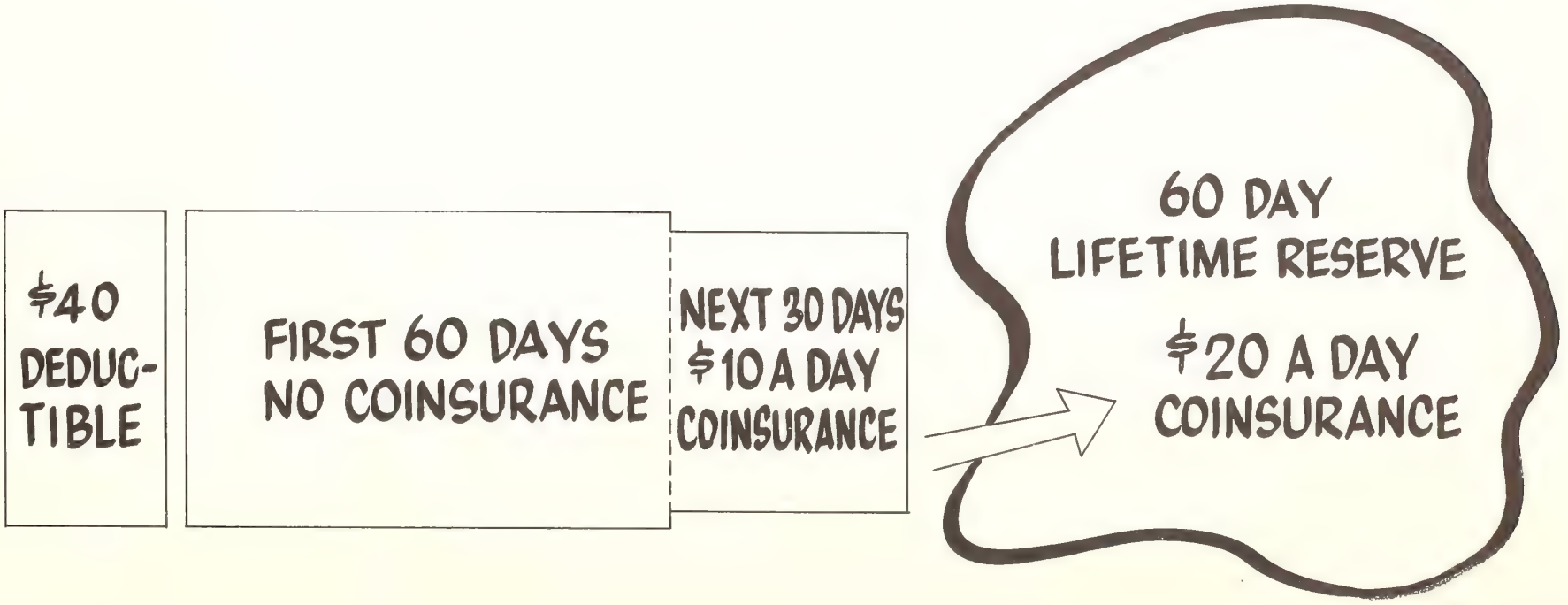


CHART NO. 42

ADDITIONAL DAYS OF HOSPITAL COVERAGE

The law now provides (effective 1/1/68) a lifetime reserve of 60 days of inpatient hospital coverage. A beneficiary will be able to draw upon these days when he exhausts his regular 90 days of coverage, spell of illness, but the reserve days used cannot exceed 60 during his lifetime. Payment will be made for such additional days of care unless the individual elects not to have such payment made (and thus save his reserve days for a later time.) Each of the reserve days is subject to $20 a day coinsurance.

The lifetime reserve is intended primarily to alleviate the problem faced by the beneficiary who has received 90 days of hospital care, requires long-term care in an extended care facility or nursing home, and while there suffers an acute illness which requires further hospitalization. Such a beneficiary has, in effect, only one spell of illness during his lifetime. The lifetime reserve of 60 days guarantees that no less than 150 days of inpatient hospital benefits will be available to him. The reserve will also, of course, be of value to the beneficiary who has several spells of illness during his lifetime but requires more than 90 days in any one of them.

Safeguards against any possible overutilization include the coinsurance feature, the limitation of 60 days during a person's lifetime, and regulations which will require appropriate verification of the medical necessity of reserve days.

Q. Will a beneficiary who has used all of his 90 days during 1967, and is still in the hospital on 1/1/68 be entitled to the reserve days?

A. Yes.

HI HOSPITAL INSURANCE BENEFIT

Effective: 1/1/68

REDUCTION OF INPATIENT HOSPITAL DAYS

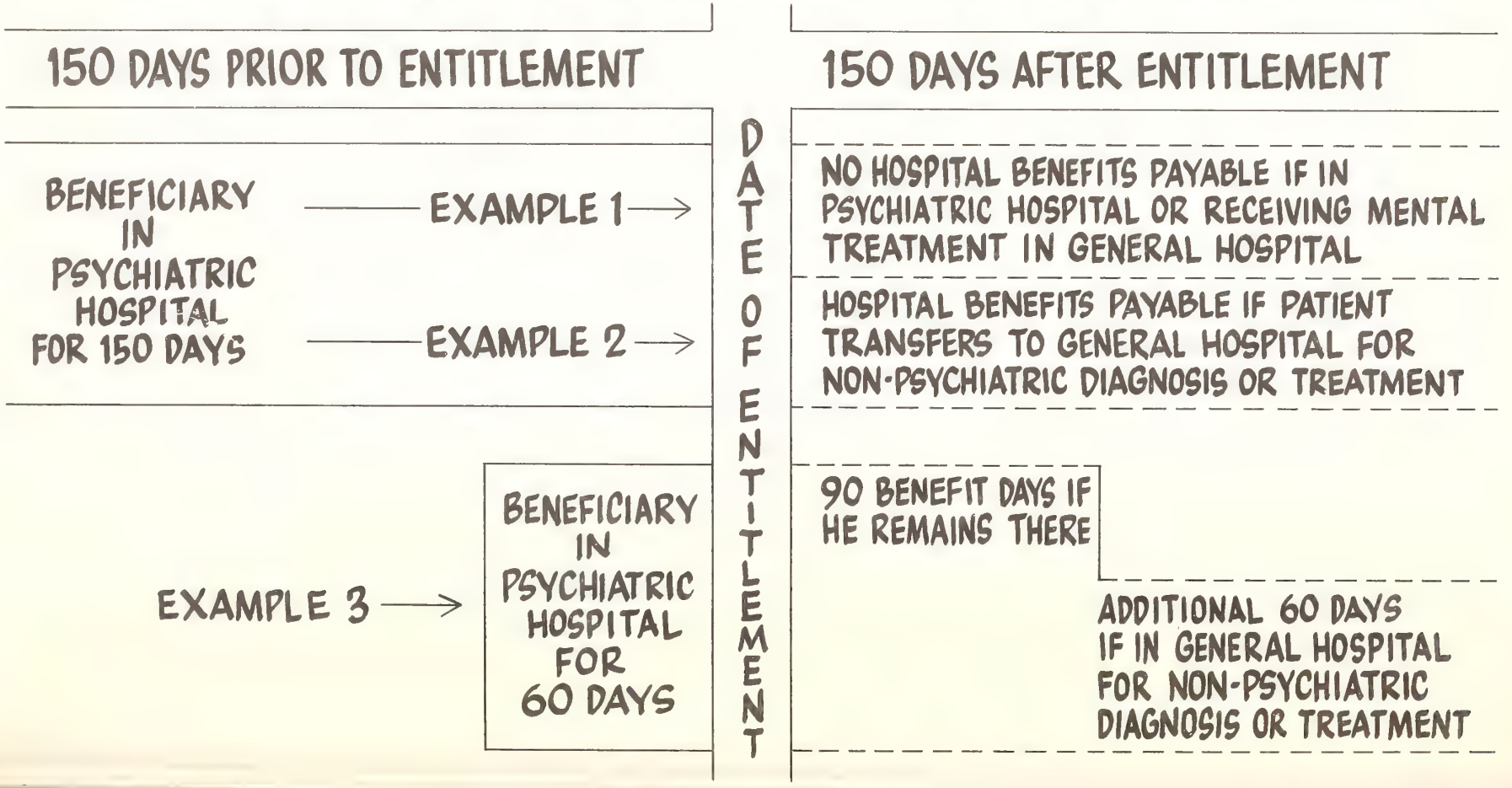


CHART NO. 43

REDUCTION OF INPATIENT HOSPITAL DAYS

The 1965 law provided for a reduction in the amount of hospital benefits payable for persons who were inpatients of participating tuberculosis or psychiatric hospitals when their medicare entitlement began. For them, the number of days for which hospital insurance could pay in the first spell of illness was reduced by the total number of days the person had been in such a hospital during the previous 90 days. The reduction applied regardless of the type of hospital the beneficiary was in after entitlement and regardless of the type of treatment received after entitlement.

The amendments make 3 changes in this area effective 1/1/68. The first change eliminates tuberculosis hospitals for purposes of the reduction. In effect, the law now makes an individual's entitlement to hospital insurance benefits the same if he received hospital services in a TB hospital as it would be if he received services in a general hospital.

The second change corrects an inequity for the patient whose entire inpatient hospital benefits are affected by the reduction because of long-term psychiatric hospitalization and who suffers some illness after entitlement, other than a psychiatric condition, which requires general hospital care. Beginning 1/1/68 the reduction will *not* apply to inpatient hospital services furnished in a participating general hospital for diagnosis or treatment of an injury or illness not primarily psychiatric in nature. For example, a long-term psychiatric hospital inpatient who suffers a heart attack, appendicitis, broken hip, etc., after attaining 65 can now have hospital benefits paid on his behalf if he transfers to a general hospital for treatment of that condition.

The third change increases the number of days for reduction purposes from 90 to 150. This makes the number of reduction days consistent with the additional 60 "lifetime reserve" days discussed in the preceding chart.

The chart gives three examples of how the reduction now applies. Example one shows the situation when a person has been in a psychiatric hospital throughout the 150-day period before entitlement and remains there (or transfers to a general hospital for psychiatric treatment) after entitlement. As under the 1965 law, no benefits are payable.

In example two, the same beneficiary transfers to a participating general hospital upon entitlement for diagnosis or treatment of an injury or illness which is not primarily psychiatric. Benefits can be paid for 150 days of such care (90 "regular" days plus 60 "reserve" days).

In example three, a beneficiary has been in a psychiatric hospital for 60 days before entitlement. In this case, 90 days of benefits (30 regular plus 60 reserve) can be paid for the continued care in that hospital. This example also shows that should the beneficiary then transfer to a participating general hospital for some other care (heart attack, etc.) 60 additional benefit days can be paid.

HI HOSPITAL INSURANCE BENEFIT

SERVICES FURNISHED BY NONPARTICIPATING HOSPITALS

- Benefits may be Paid Directly to Beneficiary
- Payment to Beneficiary Based on Reasonable Charge
  - 60% for Routine Services; 80% for Ancillary
  - 2/3's if Charges are Not Separated
- Hospitals Must Meet Certain Conditions
- Benefits Under Temporary Provision May Be Limited To 20 Days
- Effective For Admissions:
  - Temporary Provision, Before 1/1/68
  - Permanent Provision (Emergency), After 12/31/67

CHART NO. 44

SERVICES FURNISHED BY NONPARTICIPATING HOSPITALS

Under the 1965 law, payment could be made to a nonparticipating hospital for emergency services furnished to medicare beneficiaries. However, such services could only be paid for if the institution met certain statutory requirements and billed the program for medicare reimbursement.

The law now provides, under a temporary provision, applying to admissions to hospitals which occur before 1968, that reimbursement may be made to an individual who was furnished inpatient hospital services in certain nonparticipating hospitals, whether or not an emergency existed. Payment would be limited to up to 20 days in each spell of illness (subject to the $40 deductible) if the hospital was not participating in medicare; but if the hospital begins to participate in medicare before January 1, 1969, and applies its utilization review plan to the services rendered, the full 90 days of coverage could be paid for. Under this temporary provision, application for payment must be made by the patient before January 1, 1969.

A similar provision relating only to emergency services would apply with respect to admissions taking place on or after 1/1/68. Under this provision, hospitals could elect to apply for payment for all emergency services in a calendar year on a reasonable cost basis, or, if the hospital did not elect to apply, the patient could obtain payment directly on the basis of an itemized bill. The emergency care provision would also apply to outpatient diagnostic services until 4/1/68. (Effective 4/1/68, diagnostic outpatient services are covered by SMI.) Beginning 4/1/68, the emergency care provision will apply to all outpatient hospital services (diagnostic and therapeutic) covered under SMI.

A facility is considered a hospital under these provisions if it has a full-time nursing service, is licensed as a hospital, and is primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. The new definition of "emergency hospital" is retroactive to 7/1/66.

The benefits payable to the beneficiary under both the temporary and the emergency care provisions will be 60% of the hospital's reasonable charges for "routine services" plus 80% of the reasonable charges for "ancillary services," after the usual deductibles are met. (If the hospital does not make separate charges for routine and ancillary services, payment will be based on 2/3's of the charges.)

In addition, some nonparticipating hospitals may now furnish certain covered medical and other health services (e.g., x-ray, laboratory tests) which were previously payable only when furnished by participating providers, physicians, or approved laboratories. To be eligible for payment, the nonparticipating hospital must meet the new definition of "emergency" hospital and health and safety standards to be prescribed by the Secretary. Payment for covered medical and other health services furnished by nonparticipating hospitals will be made by the emergency intermediary.

Detailed instructions concerning these changes will be transmitted shortly to all intermediaries and hospitals.

HI OTHER HOSPITAL INSURANCE

TRANSITIONAL INSURED STATUS

YEAR ATTAINS 65	QC's UNDER 1965 LAW		QC's UNDER 1967 LAW	
	MEN	WOMEN	MEN	WOMEN
1967 (OR EARLIER)	0	0	0	0
1968	6	6	3	3
1969	9	9	6	6
1970	12	12	9	9
1971	15	15	12	12
1972	18	18*	15	15
1973	21	19*	18	18
1974	23*	20*	21	20*
1975	24*	21*	24*	21*

* QC's Required Equal Fully Insured Status

CHART NO. 45

TRANSITIONAL INSURED STATUS

Under the 1965 law, persons who attained 65 in 1967 or earlier were eligible for hospital insurance protection even though they had not earned any quarters of coverage under the social security or railroad retirement programs; persons who attained 65 in 1968 had to have earned at least 6 quarters of coverage to be eligible.

On later consideration, the initial increase to 6 QC's seemed too sharp. Therefore, the new law provides that the minimum number of QC's required for entitlement under this transitional insured status is 3 for people attaining 65 in 1968. The required number of QC's increases by 3 for each subsequent year until the regular insured status requirement is reached.

This transitional provision will phase out so that by 1975 (1974 for women) the same number of QC's will be required for entitlement to monthly cash benefits and hospital insurance benefits. The cost of hospital insurance protection provided under this provision will continue to be financed from general revenues rather than from the Federal Hospital Insurance Trust Fund. The adjacent table shows the 1965 and 1967 requirements for entitlement.

It is the intent of the Congress that, over the long run, only persons who are fully insured or are dependents of insured persons will have hospital insurance protection. The transitional insured status provision is included in the law to benefit the present aged who might have retired before their type of job was covered. If these people were not afforded protection, the problem the hospital insurance program is designed to meet—high hospitalization and hospital-related expenses combined with greatly reduced income—would remain unsolved for many years. At the same time, to extend the "special" protection indefinitely into the future for those persons who have not contributed towards social security would be unfair to people who are required to contribute. This transitional provision is, therefore, designed to "wash out" after a few years.

HI OTHER HOSPITAL INSURANCE

Effective: For Earnings in 1968 and later

REFUND OF TAX OVERPAYMENTS

Excess Hospital Insurance Tax Paid by Workers under Both Social Security and Railroad Retirement may be Refunded

CHART NO. 46

REFUND OF TAX OVERPAYMENTS

If a person works in covered employment for more than one employer and pays more than the maximum amount of social security tax, the excess may be claimed as a credit against his Federal income tax.

However, if an employee has social security contributions withheld by one employer and also makes railroad retirement contributions from another job, he is not entitled to a credit resulting from the combination because (apart from hospital insurance) the two programs provide for separate and distinct taxes and benefits.

Although the hospital insurance tax and benefits are identical under both programs, no refund or credit for excess HI tax could be given under prior law. The 1967 amendments correct this and allow an employee (or self-employed person) who pays both social security and railroad retirement tax to claim any excess hospital insurance tax as a credit against his Federal income tax.

This is effective for wages in calendar year 1968 and later, and for self-employment income in taxable years ending on or after 12/31/68.

HI MEDICAL INSURANCE BENEFIT

Effective: 1/1/68

CERTAIN PODIATRISTS' SERVICES COVERED

- COVERED:
  - Diagnosis and Treatment of Foot Disorders
- NOT COVERED:
  - Treatment of Flat Feet
  - Treatment of Subluxations
  - Routine Foot Care

CHART NO. 47

CERTAIN PODIATRISTS SERVICES COVERED UNDER SMI

Effective 1/1/68, services of doctors of podiatry or surgical chiropody are covered under the SMI program as physicians' services, but only with respect to functions which they are authorized to perform by the State where they practice. However, certain specified foot care services will now be excluded whether performed by a podiatrist or medical doctor. These exclusions include treatment of flat foot conditions, the prescription of supportive devices for such conditions, treatment of subluxations of the foot, and routine foot care (including cutting or removal of corns, warts or callouses, trimming of nails and other routine hygenic care.)

Under the amendments, podiatrists are not considered to be "physicians" for purposes of serving as physician members of utilization review committees (although they may serve as non-physician members), for certifying or recertifying as to the medical necessity of inpatient institutional care, or for the various physician activities required in connection with extended care and home health provider services.

Beneficiaries may now receive covered services from either a medical doctor or podiatrist for those types of treatment which medical doctors ordinarily provide but which podiatrists are also legally authorized to perform. The specific exclusion of certain types of foot care, regardless of who performs it, should not significantly reduce previous coverage of treatment of foot ills by medical doctors since ordinarily they do not perform the excluded types of care.

Claims for podiatrists services should be submitted to the SMI carrier in the same manner as claims for other physicians' services.

HI MEDICAL INSURANCE BENEFIT

Effective: 1/1/68

PURCHASE OF DURABLE MEDICAL EQUIPMENT

WHEN? – A physician states the equipment is medically necessary and ...

– The beneficiary chooses to purchase rather than rent

HOW? – Monthly Installments for expensive equipment (over $50)

– Lump-sum Payment for most inexpensive items ($50 or less)

CHART NO. 48

PURCHASE OF DURABLE MEDICAL EQUIPMENT

Effective 1/1/68, beneficiaries whose medical conditions require durable medical equipment for use in their homes, such as wheelchairs, and who choose to purchase rather than to rent this equipment, can receive SMI reimbursement toward the purchase. Benefits for the purchase of items of durable medical equipment (items which cost more than $50) will be paid in monthly installments equal to the payments that would have been made had the patient chosen to rent. For inexpensive equipment (that which costs $50 or less), a lump-sum payment will be made when the carrier determines that this is more practical or less costly than periodic payments. Periodic payments will be made, however, only for the period of time the equipment is determined to be medically necessary or until the reasonable purchase price of the equipment has been reimbursed, whichever comes first. Rental of this equipment is covered as under the 1965 law.

Purchase of equipment was not authorized under the 1965 law. By including the purchase provision, the law is now more responsive to those situations where it would be more economical or more practical to purchase rather than rent durable medical equipment. Periodic purchase payments rather than a lump-sum payment is provided for more costly equipment to avoid paying the full purchase price of the equipment used only a short time and, thereby, allowing the patient (or his estate) to profit from its disposition.

Q. Who decides whether to rent or purchase?

A. In all cases, the decision to rent or purchase is left to the beneficiary and SMI payment will be made accordingly.

Q. Can a beneficiary who is now renting purchase his equipment and receive reimbursement?

A. Yes.

Q. What about coverage of oxygen for oxygen related equipment such as pressure breathing machines and oxygen tents?

A. Oxygen is covered in these cases, whether the equipment is rented, or purchased, provided it is required for the effective use of the equipment.

Q. When will periodic payments for the purchase of durable medical equipment end?

A. When medical necessity for the equipment no longer exists or when total monthly payments equal the reimbursement payable, whichever comes first.

Q. Who pays the remaining amount due when medicare benefits stop because the equipment is no longer medically necessary and the supplier has accepted an assignment?

A. The beneficiary is responsible for paying the unpaid part of the purchase price when payments stop because his condition has changed and the equipment is no longer medically necessary. Similarly, when payments stop because the beneficiary dies, his estate is responsible for the remaining amount due.

Q. If the patient dies and periodic purchase payments were being made, how is disposition of the equipment made?

A. Disposition will be decided upon and made by the estate just as though there had never been an SMI claim. The program will not "repossess" any equipment.

Q. Does the $50 medical insurance deductible apply?

A. Yes, as does the 20% coinsurance requirement.

HI MEDICAL INSURANCE BENEFIT

Effective: 7/1/68

OUTPATIENT PHYSICAL THERAPY SERVICES

SERVICES FURNISHED BY PARTICIPATING:

- HOSPITALS
- EXTENDED CARE FACILITIES
- HOME HEALTH AGENCIES
- CLINICS
- REHABILITATION AGENCIES
- PUBLIC HEALTH AGENCIES

IN EITHER OUTPATIENT DEPARTMENT OR HOME

PATIENT

COVERED BY SMI

CHART NO. 49

CERTAIN OUTPATIENT PHYSICAL THERAPY SERVICES COVERED UNDER SMI

Effective 7/1/68, the medical insurance program will provide reimbursement (after the $50 SMI deductible has been met) for 80% of the reasonable cost of outpatient physical therapy services furnished to beneficiaries by participating providers of services or by others under arrangements with such providers.

For the physical therapy services to be covered, the beneficiary must be under the care of a doctor of medicine or osteopathy who certifies as to the medical necessity for the outpatient services and establishes and periodically reviews a plan describing the type, amount, and duration of the therapy.

For the purpose of this provision, the term "provider of service" has been expanded to include clinics, rehabilitation agencies, and public health agencies which meet the following conditions:

1. It provides an adequate physical therapy program for outpatients and has facilities and personnel to supervise the program; and
2. Has policies established by a group of professional personnel, including at least one medical doctor or osteopath (associated with the clinic or rehabilitation agency) and one physical therapist to govern the services; and
3. Maintains clinical records on all patients; and
4. Where applicable, is licensed or approved as meeting the standards established for such licensure in the State in which the clinic or rehabilitation agency is located; and
5. Meets health and safety regulations to be established by the Secretary.

State agencies will determine whether an institution or organization meets the conditions for participation. So that this work can be completed, and to allow time for clinics and agencies to make any changes necessary, the effective date of the provision (7/1/68) is later than the date for most other provisions.

This new provision of the law represents an extension of coverage in that under the 1965 law, individuals who were not homebound (and therefore were ineligible for home health benefits) could receive covered outpatient physical therapy services only if provided as an incident to a physician's services or as a hospital service furnished incident to a physician's services. Such individuals may now receive such services from any "provider of services," as that term has been expanded above, without the requirement that such services be furnished under the personal supervision of a physician.

HI MEDICAL INSURANCE BENEFIT

Effective: 1/1/68

PAYMENT FOR CERTAIN PORTABLE X-RAY SERVICES PERFORMED IN A BENEFICIARY'S HOME

- TESTS PERFORMED UNDER A PHYSICIAN'S GENERAL SUPERVISION
- EQUIPMENT AND OPERATORS MEET HEALTH AND SAFETY REGULATIONS

CHART NO. 50

SMI PAYMENT FOR CERTAIN PORTABLE X-RAY SERVICES

Effective 1/1/68, SMI payment for diagnostic X-ray services performed by non-physician X-ray operators in a beneficiary's home can be made if certain conditions are met. The operator's services have to be performed under the general supervision of a physician in a place of residence used as the patient's home and the performance of these services meet the health and safety requirements to be prescribed by the Secretary. (The definition of "place of residence" is the same for this provision as is now used for home health care benefits purposes.)

Under the 1965 law, diagnostic X-rays were covered under the SMI program only when the procedures were performed by a physician himself or when they were performed under his direct personal supervision, and the physician included the charges for these services in his own bill. Thus, the services furnished by a non-physician X-ray operator to a beneficiary in his home were covered by the 1965 law only if a physician accompanied him to the patient's home, personally supervised the taking of the X-ray, and billed for the services.

The change in the law will facilitate diagnosis in cases where it is difficult for the patient to receive X-rays outside his home because he is bedridden or unable to obtain transportation suitable to his condition.

Q. Must the patient be confined to his home because of a medical condition?

A. No. There is no requirement that the patient be unable to leave home.

Q. Can the qualified non-physician operator bill directly?

A. Yes. He can bill the patient directly or accept assignment. Payment will be based on reasonable charges.

Q. What "health and safety" regulations are anticipated?

A. Final regulations have not been issued yet, but generally they will deal with the professional education, training, and level of competency of the operator and the condition of the equipment (e.g., proper shielding and acceptable radiation levels). These standards are very important because of the potential hazards to a patient's health or to the health of other individuals exposed to radiation from the improper use of this dangerous equipment.

Q. Who will survey X-ray equipment and operators to determine if the conditions are met?

A. No final decision has been made, but probably State agencies will be used. However, since the development and application of regulations pertaining to health and safety conditions for the performance of portable X-ray services cannot be completed prior to 1/1/68, the effective date of the change, a temporary interim procedure similar to the one established for independent labs will be implemented until all surveys can be completed and a "cut off" date set. It is contemplated that State licensing or registration requirements relative to the operators of radiological equipment will have to be met as part of the interim procedure.

HI MEDICAL INSURANCE BENEFIT

Effective: 4/1/68

INPATIENT ANCILLARY SERVICES IN PARTICIPATING INSTITUTIONS

- Certain "MEDICAL & OTHER HEALTH SERVICES" furnished to inpatients of participating providers Covered by SMI if Beneficiary not Eligible for HI Benefits.
- Regular SMI Deductible and Coinsurance Apply

CHART NO. 51

INPATIENT ANCILLARY SERVICES IN PARTICIPATING INSTITUTIONS COVERED BY SMI

Under the 1965 law, no payment could be made under medical insurance program for any services (other than physicians' services) furnished to inpatients of participating hospitals or extended care facilities. Payment for such inpatient services could only be made under the hospital insurance program.

The new law makes medical insurance benefits payable for certain ancillary services furnished to inpatients of participating hospitals and extended care facilities. Effective 4/1/68, inpatients of participating providers will be able to receive reimbursement for certain medical and other health services under SMI if the services are not reimbursable on the patient's behalf under the hospital insurance plan. For example, an inpatient of a participating hospital who has exhausted his hospital insurance payment days in a spell of illness may be reimbursed for diagnostic laboratory, X-ray, and other diagnostic tests, prosthetic devices, braces, splints, etc., which he receives. Similar claims for reimbursement could be made by an inpatient of an extended care facility who has exhausted his days of coverage or who fails to meet some other eligibility requirement, for example, the 3-day hospital stay prior to admission to the facility.

When services which are covered under the medical insurance program are furnished by a participating provider (either directly or under arrangements), payment will be made on a cost basis. When furnished by other than a participating provider, reimbursement will be on a charge basis to the patient or to the supplier if he accepts assignment. In either case, payment will be subject to the usual medical insurance deductible and coinsurance provisions.

HI MEDICAL INSURANCE BENEFIT

Effective: 1/2/68 (The Date of Enactment)

EXCLUSION OF REFRACTIVE PROCEDURES

EVEN WHEN:

- Performed by a Physician
- Total Exam is Treatment or Diagnosis of Eye Disease

CHART NO. 52

EXCLUSION OF REFRACTIVE PROCEDURES

The 1965 law excluded from coverage expenses incurred for eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses.

Effective 1/2/68 (the date of enactment), the law excludes from coverage all procedures to determine the refractive state of the eyes performed during any eye examination (even in connection with furnishing prosthetic lenses). The exclusion applies whether the refractions are performed by ophthalmologists, other physicians, or optometrists, and whether the total examination is for the treatment or diagnosis of eye disease or injury.

"Refractions" are procedures necessary to prescribe the correct lens power to help the eye focus images sharply on the retina. The lens thus improves the vision of people who are nearsighted, farsighted, astigmatic, etc.

Although the 1965 law excluded refractions performed for the purpose of prescribing, fitting, or changing eyeglasses, such procedures were covered when performed by a physician as a part of a more general examination to treat or determine the nature or extent of eye disease or injury. Therefore, medicare payment for refractions could depend on whether it was performed by an optometrist or physician. The new law eliminates this distinction by excluding all procedures performed to determine the refractive state of the eyes, regardless of who performs them.

The eyeglasses and eye examination exclusion in effect under the 1965 law continues to apply; i.e., all of the services and procedures are excluded when an eye examination is performed for the purpose of prescribing, fitting, or changing eyeglasses without regard to whether these services are furnished by a physician or by another practitioner.

HI OTHER MEDICAL INSURANCE

Effective: 1/2/68 (The Date of Enactment)

PAYMENT FOR DECEASED BENEFICIARIES

- BILL WAS PAID - LIST OF PRIORITIES:
  1. Person or Persons who paid the bill
  2. Legal representative of the estate
  3. Surviving spouse living with or entitled
  4. Entitled child or children
  5. Entitled parent or parents
  6. Surviving spouse not living with, not entitled
  7. Child or children not entitled
  8. Parent or parents not entitled
- BILL NOT PAID – Payment to physician (or supplier) only if:

  reasonable charge accepted as full charge

CHART NO. 53

SMI PAYMENT ON BEHALF OF A DECEASED BENEFICIARY

The new law now provides a list of payee priorities in cases where a beneficiary incurs expenses covered by the medical insurance program and dies before program payment can be made and before an assignment is effected. The 1965 law contained no specific provision regarding these cases and payments have been made, in accordance with applicable State law, to the legal representative of the estate or, if none existed, to alternative payees under administrative procedures.

In cases where a beneficiary who has received covered SMI services dies, and the *bill has been paid* (but reimbursement has not been made), the benefits will now be authorized to the person (or persons) who paid the bill. If the deceased beneficiary had paid the bill, payment will be made to the legal representative of his estate. When there is no legal representative, payment will be made to relatives of the deceased in the following priority: (a) the surviving spouse either living with the deceased at the time of death or entitled to monthly social security or railroad retirement benefits based on the same account as the deceased; (b) the child or children of the deceased (in equal parts) who were entitled to monthly benefits based on the same account as the deceased; (c) the deceased's parent or parents if entitled to benefits on the same account as the deceased; (d) the surviving spouse who was neither living with nor entitled to benefits on the same account as the deceased; (e) the deceased's child or children not entitled; (f) the deceased's parent or parents not entitled. If none of these persons exist, no payment will be made. If the bill was paid by a person other than the beneficiary, and that person has died, payment will be made according to the above priority. If none of the listed individuals exist, payment will be made to the legal representative of the beneficiary's estate.

In cases where a beneficiary who has received covered SMI services dies, and the *bill has not been paid,* program payment will be made to the physician (or other supplier) who provided the services, but *only* if the physician (or other provider) agrees to accept the reasonable charge as determined by the carrier as the full charge for the services. Otherwise, no payment will be made.

Q. Will the carrier or social security district office be responsible for developing the necessary information for payment according to the priorities?

A. The carrier will have primary responsibility but district offices will give assistance when necessary.

More complete guidelines about necessary forms, the amount of district office development assistance, etc., will be issued in regular manual instructions.

HI OTHER MEDICAL INSURANCE

TIME LIMIT FOR FILING REASONABLE CHARGE CLAIMS FOR SERVICES RENDERED IN:

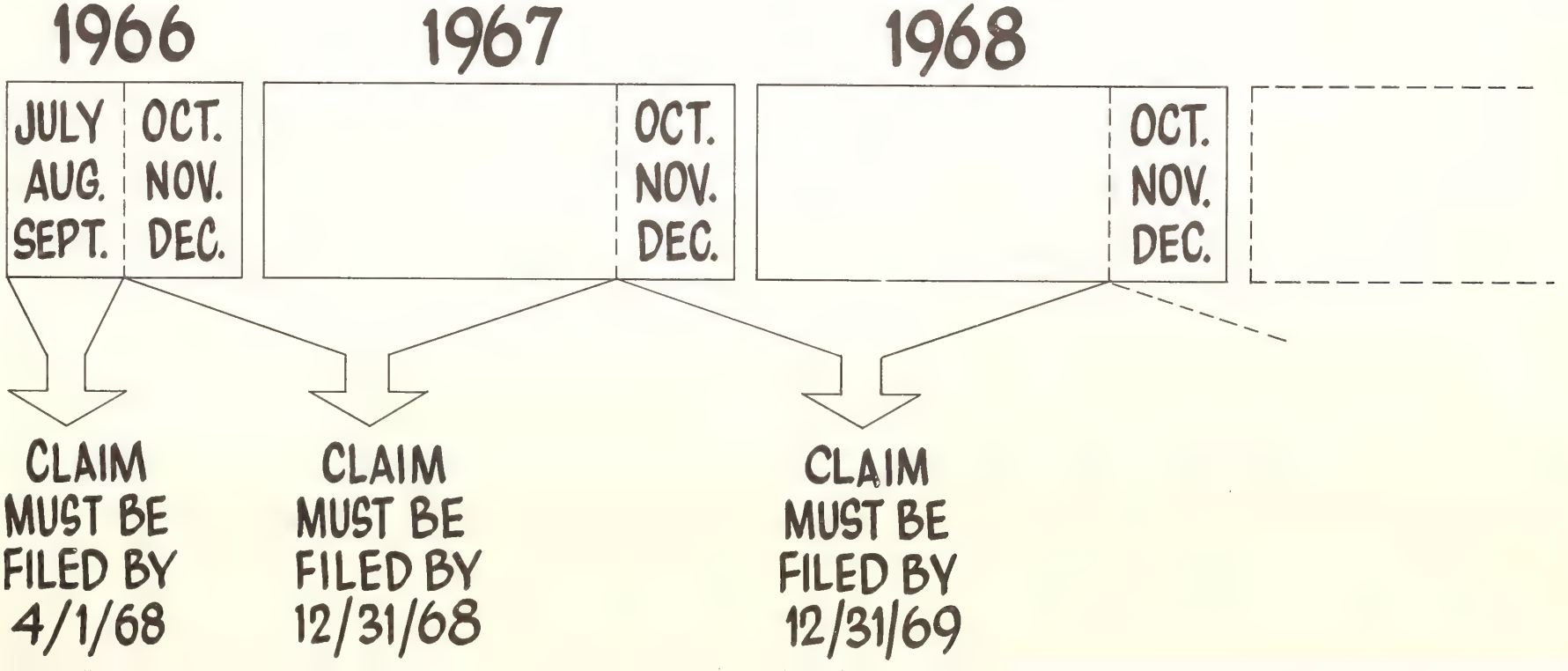


CHART NO. 54

TIME LIMIT FOR FILING CLAIMS BASED ON REASONABLE CHARGE

The 1965 law provided authority to establish a time limitation on claims filing by hospitals and other providers of services that are reimbursed by medicare on a reasonable cost basis. There was, however, no such limitation for claims based on reasonable charge reimbursement.

The law now provides a time limit on filing claims for payment of physicians' fees and other SMI services reimbursable on a reasonable charge basis. These claims must be filed no later than the end of the calendar year following the year in which the services were furnished; except that services furnished in the last 3 months of any calendar year will be deemed to have been furnished in the following year. For example, services rendered in October-December 1967 will be deemed to have been furnished in 1968. The time limit for filing these claims would expire on December 31, 1969. As the chart shows, there is a special provision for beneficiaries who received covered services in the first 3 months of the program—they *may lose benefits* unless they file by March 31, 1968.

The time limit will allow beneficiaries, physicians and other claimants ample time to file medical insurance claims. It will also promote efficient administration by avoiding the handling of claims which, by reason of their age, are not readily subject to verification. The "last 3 months" rule is included in the law because expenses furnished in the last calendar quarter of a year may be counted toward the deductible for the following year; hence the time for the "carryover" provision and the time limit rule are consistent.

HI OTHER MEDICAL INSURANCE

Various Effective Dates

SMI ENROLLMENT AND PREMIUM CHANGES

- General Enrollment Period is January 1-March 31 of Each Year, Beginning in 1969
- Premium Rate to be Announced in December of Each Year, Beginning December 1968, and Effective the Following July
- Enrollees May Disenroll at Any Time Beginning 4/1/68, to be Effective Last Day of Following Quarter
- Person can Enroll Anytime During a General Enrollment Period Beginning Within 3 years of the Close of His Initial Enrollment Period
- Premium rate is increased from $3 to $4 a month starting 4/1/68

CHART NO. 55

SMI ENROLLMENT AND PREMIUM CHANGES

There are four changes in this area. The first establishes new dates for general enrollment periods. Effective beginning 1969, general enrollment periods will be January 1 through March 31 of each year. The general enrollment periods under the 1965 law were October 1 through December 31 of each odd-numbered year.

The second change requires the Secretary to establish and announce premium rates each year during December, beginning in 1968. The "new" rate (there may not be any change in some years, of course) will become effective the following July. Each time, the Secretary will give the actuarial assumptions and bases used in arriving at the rate. The 1965 law required the premium rate to be determined in each odd-numbered year and it was applicable for the succeeding two years.

The third change is effective 4/1/68. It allows an SMI beneficiary to file a notice at any time during the year that he wishes to disenroll. His coverage will cease at the close of the calendar quarter following the calendar quarter in which he files the notice, provided it was not terminated earlier for nonpayment of premiums. The 1965 law restricted requests for disenrollment to October 1-December 31 of each odd-numbered year, with termination effective the end of that year.

These three changes were adopted in view of the situation that developed while the 1967 amendments were pending. Since the legislation included changes in benefits which affected the premium rate, and it was still pending during the 1967 general enrollment period, Public Law 90–97 was enacted to extend the $3 premium and the 1967 general enrollment period through March 1968 and extend the deadline for announcing any change in the premium rate to 12/31/67. The new rate, effective 4/1/68, was established at $4 a month and will remain at that rate through 6/30/69.

Providing a July 1 effective date for any premium change after 1968 makes the change effective at the same time coverage begins for people who enroll during a general enrollment period. It also allows people to terminate their coverage after a premium increase without paying the higher amount in any month (if they do so before April 1). Allowing enrollees who have their premiums automatically withheld from monthly checks to disenroll at any time makes their right to terminate more in line with those who may do so simply by the nonpayment of premiums.

Effective 4/1/68, an individual enrolling for the first time can enroll at any time in a general enrollment period that begins within 3 years of the close of his initial enrollment period. The 1965 law limited enrollment to three years after the close of the initial enrollment period, even if the 3-year period ended during a general enrollment period. This change gives eligible people a full 3-month period following the announcement of a new premium rate to decide about enrollment.

HI OTHER MEDICAL INSURANCE

Effective: 2/1/68

LATE ENROLLMENT IN SMI WITHOUT PENALTY

When:

- Claimant has Documentary Evidence showing Incorrect Age
- Claimant has relied on this and Delayed Filing

DATE SHOWN ON INCORRECT DOCUMENT WILL BE USED AS BASIS FOR ENROLLMENT

CHART NO. 56

ENROLLMENT IN SMI BASED ON ALLEGED DATE OF ATTAINING 65

The law now allows a person to enroll in SMI after his initial enrollment period where the person delayed filing because, relying on erroneous documentary evidence, he was mistaken about his age. In such cases the date of attainment shown in the erroneous documentary evidence will be used for all SMI purposes—determining the dates of his initial enrollment period, date of effective eligibility, and his premium rate. This provision is effective for enrollments occurring after January 1968.

The 1965 law made no provision for excusing individuals who attempted to enroll sometime after they reached 65 because they were mistaken about their age. Thus, it was possible for a person to get cash benefits and hospital insurance benefits retroactively for 12 months but have to wait up to 2½ years before medical insurance protection could begin.

HI OTHER MEDICAL INSURANCE

Effective: 1/2/68 (The Date of Enactment)

COORDINATION OF TITLE XIX AND SMI PROGRAMS

Before

A. States could buy-in to SMI for their cash public assistance recipients 65 and over.

B. Buy-in agreements had to be requested by a State before 1/1/68.

C. States could not include individuals who would have become eligible after 12/31/67 in the agreements.

Now

A. States can buy-in for an additional group---the aged eligible for medicaid who are not receiving cash payments.

B. The time limit for States to request agreements is extended to 1/1/70

C. Individuals who become eligible anytime after 12/31/67 are covered under the agreements.

D. No Federal Matching Funds will be paid to States under Title XIX: (1) For SMI services which could have been covered under SMI had the individual been enrolled. (2) To help them pay their part of the SMI premiums for people who are not money payment recipients.

CHART NO. 57

COORDINATION OF TITLE XIX AND SMI PROGRAMS

The States now have the option to "buy-in" for all of their aged (65 and over) who are eligible for medical assistance under Title XIX. The 1965 law provided this buy-in for only the aged who were receiving cash public assistance payments. This change will affect between 1 and 2 million people whose income levels and assets make them ineligible for cash assistance payments but who are still "medically needy" as defined by the States. SMI protection will be effective for the new groups the third month after the agreements are made. For individuals who become eligible after the agreement (or modification) is made, this 2-month waiting period protects the SMI program from immediate claims from people already ill when the revised agreements are made or when eligibility first occurs after the agreements are made.

The deadline for a State to request a buy-in agreement between the State and the Secretary of Health, Education, and Welfare has been extended through 12/31/69. Individuals who become eligible for buy-in after that date (i.e., attain age 65 or become "medically needy") will be covered by the agreements also. Under the 1965 law, individuals becoming eligible for buy-in after 12/31/67 were *not* covered under the original agreement.

To give maximum incentive for States and individuals to maintain SMI coverage, the law now provides that no Federal financial aid will be given to States under Title XIX for medical expenditures which would have been covered by SMI had the individual been enrolled. Under the 1965 law, aged residents of some States had little incentive to enroll in (or not drop) SMI coverage because the State assistance programs were so extensive.

The law now also provides that no Federal financial aid will be given to States for the premium payments made by them on behalf of the individuals eligible only for medical assistance under Title XIX. This recognizes that one-half of the SMI cost is already met by general revenues and that it seems inappropriate to provide additional Federal financial aid in this area.

HI OTHER PROVISIONS

Effective: 1/1/68

3-PINT BLOOD DEDUCTIBLES

- Now Applies to SMI as well as to HI
- Includes Packed Red Blood Cells

CHART NO. 58

BLOOD DEDUCTIBLES

There are two changes in the 3-pint blood deductible provision in the 1965 law. The changes are effective for blood furnished after 12/31/67. The first change establishes a 3-pint blood deductible under the medical insurance program. This is now consistent with the blood deductible under the hospital insurance program. The two 3-pint deductibles are applied separately, without respect to whether one or the other has been met. The HI deductible applies in every spell of illness; the SMI deductible in every calendar year.

Secondly, the definition of "blood" is changed to include units of packed red blood cells (a blood derivative) for deductible purposes. Therefore, program payment cannot be made to or on behalf of a beneficiary receiving units of packed red blood cells until the appropriate deductible has been met.

The 1965 law established the blood deductible for hospital insurance to encourage replacement of the blood furnished medicare beneficiaries. Since there is a great and growing need for blood, the changes in the deductible requirement are designed to increase the incentive for medicare beneficiaries receiving blood to replace the blood and red cells they receive. Continual donations of fresh whole blood are necessary to supply packed red blood cells and the deductibles will create a replacement incentive for those using this blood derivative.

As under the 1965 law, a beneficiary may meet the deductibles either by payment or replacement of the blood used. This recognizes that older people have unusual difficulties replacing blood.

Q. Can the SMI blood deductible help meet the regular SMI $50 deductible?

A. No, they are separate and each must be met.

OTHER PROVISIONS

MEDICARE FOR THE DISABLED??

AN ADVISORY COUNCIL TO STUDY-

- The extent of their need for Medicare
- The cost of this protection
- Ways of financing

REPORT DUE- 1/1/69

CHART NO. 59

ADVISORY COUNCIL TO STUDY MEDICARE FOR DISABLED

Extensive consideration was given to extending health insurance protection to the disabled. However, it was concluded not to recommend this extension of protection at the present time.

A major factor in this decision was that data which first became available while the proposal was being considered indicated that the per capita cost of providing health insurance for the disabled under medicare would be considerably higher than is the cost of providing the same coverage for the aged. As a result of the new data, the cost estimates of the proposal increased significantly.

The estimated difference between the cost of medicare for the disabled and for the aged also raised questions as to what would be the most equitable way of financing medical insurance coverage.

Therefore, an extension of medicare to the disabled was deferred. There is, however, a provision in the amendments under which an Advisory Council will be appointed in 1968 to study the question of extending medicare to the disabled, including the unmet need of the disabled for health insurance protection, the costs involved in providing this protection, and the ways of financing this protection. The Council is to submit a report of its findings to the Secretary of Health, Education, and Welfare not later than 1/1/69. The Council is also to make recommendations on how this protection should be financed and on the extent to which the cost of this protection could appropriately be borne by the present health insurance trust funds.

The Advisory Council will be made up of 12 members appointed by the Secretary of HEW representing organizations of employees and employers, and self-employed persons and the public. The Council will cease to exist after its report is transmitted to the Congress.

HI OTHER PROVISIONS

INCENTIVES FOR LOWERING HEALTH COSTS

DHEW WILL EXPERIMENT WITH NEW PAYMENT METHODS TO:

- Provide Incentives for Increasing Efficiency and Economy in Delivery of Health Services.
- Maintain or Increase the Quality of Care

(Applies to Medicaid and Maternal and Child Health Programs also)

CHART NO. 60

INCENTIVES FOR LOWERING HEALTH COSTS

Medicare payments are made either on a "reasonable cost" or the "resonable charge" basis. Participating providers of services, such as hospitals, extended care facilities, home health agencies, and, in certain cases, group practice prepayment plans, are reimbursed on a reasonable cost basis. Medicare payments for covered services rendered by physicians and other persons who are not "providers" are made on a reasonable charge basis.

The new law authorizes the Secretary of Health, Education, and Welfare to experiment with alternative methods of reimbursement to organizations and physicians under the medicare, medicaid (Title XIX) and maternal and child health (Title V) programs. The experiments would test various incentives for increasing the efficiency and economy of delivering health services without adversely affecting the quality of care. Experiments may involve only those physicians, institutions, and organizations that agree to participate and may not be initiated until the Secretary obtains the advice and recommendations of specialists competent to evaluate the possibility of securing productive results.

The Secretary will make an annual report to the Congress about the experiments.

HI OTHER PROVISIONS

DRUG STUDY

The Secretary Will Study :

1. Quality and Cost Standards for Drugs
2. Coverage of Drugs under Health Insurance

Report Due 1/1/69

CHART NO. 61

DRUG STUDY

In establishing the medicare program in 1965, the Congress considered the question of covering drugs and biologicals. Congress clearly recognized that the cost of prescription drugs can be extremely burdensome for the aged but, after careful deliberation, decided to limit the coverage of drugs to those furnished as a part of the services commonly provided inpatients of hospitals and extended care facilities and those drugs which are furnished as a part of a physician's services and which cannot be self-administered.

The experience of public and private drug benefit programs indicates that the coverage of drugs is extremely complicated and merits further study before additional drug coverage can be provided under medicare. Some of the problems, for example, are limiting coverage to medically essential drugs, providing that payment will be made only for reasonable costs or charges, assessing the therapeutic effectiveness of prescribed drugs, and devising effective administrative mechanisms to handle the large number of very small bills that would be involved. In addition, financing for expensive additional drug coverage must be provided.

Accordingly, the law requires the Secretary of Health, Education, and Welfare to study quality and cost standards for drugs for which payments are made under the Social Security Act and coverage of drugs under SMI and report the findings of fact and any conclusions or recommendations to the President and the Congress by 1/1/69.

HI OTHER PROVISIONS

- STUDY OF COVERING ADDITIONAL SMI SERVICES PROVIDED BY INDEPENDENT LICENSED PRACTITIONERS

  REPORT DUE 1/1/69

- TRANSFER OF NATIONAL MEDICAL REVIEW COMMITTEE FUNCTIONS TO HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

- COST OF STATE CONSULTATIVE SERVICES UNDER MEDICARE TRANSFERRED TO TITLE XIX

  EFFECTIVE 7/1/69

CHART NO. 62

STUDY OF ADDITIONAL SERVICES FOR COVERAGE UNDER SMI

The new law requiries the Department to study the question of adding to the services now covered by SMI, services of additional types of licensed practitioners performing health services in independent practice. The results of the study will be reported to the Congress prior to 1/1/69. The report must include findings regarding the need and cost of such coverage and include recommendations as to the priority of covering these services, methods of coverage, and safeguards that should be included if any such services are covered.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Under the new law, the membership of this Council is increased from 16 to 19 persons and the Council is assigned the responsibilities of the National Medical Review Committee. The latter committee will therefore not be formed.

The Council will continue to advise the Secretary on general administrative policy and formulation of regulations. In line with their new responsibilities they will study utilization of covered health and medical services and will recommend necessary changes in the way health services are used, modifications in administration, and changes in the law relevant to utilization.

STATE FACILITIES FOR CONSULTATIVE PURPOSES

Under the 1965 law, States could be reimbursed by medicare for 100% of the cost of consultative services provided by the State agencies to hospitals, extended care facilities and home health agencies. This consultation is designed to help them establish and maintain fiscal records, utilization review procedures and to otherwise qualify as providers of services.

The law now provides for State agency consultation to health care organizations and institutions to enable them to qualify for payment under the medicaid (Title XIX) and maternal and child health (Title V) programs as well. Because these services are more a public health function and are for the benefit of people of all ages, the cost of providing all consultation will be shared by the States and the Federal Government on the same basis as other costs States bear in carrying out their assistance programs. The expanded consultative service provision is effective 7/1/69. Also at that time the related medicare provisions will be repealed.

HI OTHER PROVISIONS

Effective : 1/2/68 (The Date of Enactment)

- CIVIL SERVICE AND SMI

  FEHBA MAY REIMBURSE CERTAIN ANNUITANTS FOR SMI PREMIUM PAYMENTS

- SMI TRUST FUND
  - INTEREST PAYMENTS FOR LATE TRANSFER FROM GENERAL REVENUE FUNDS
  - CONTINGENCY RESERVE FROM GENERAL REVENUES AVAILABLE THROUGH 1969

CHART NO. 63

CIVIL SERVICE AND SMI

After enactment of the medicare program, most private health insurance plans modified their benefits and/or premium rates for people 65 and over to take account of the increased protection medicare beneficiaries have. In contrast, plans operating under the Federal Employees Health Benefits Act of 1959 are unable (under that law) to similarly adjust their rates for civil service annuitants. Therefore, the annuitants covered by both the 1959 act and SMI, unlike almost all other aged persons, do not receive protection equivalent to their combined SMI and FEHBA premiums.

As a partial remedy to this problem, the law now permits plans approved under the 1959 act to reimburse annuitants entitled under both programs for amounts up to the full amount of their SMI premiums, provided such reimbursement is financed from funds other than the contributions made by the Government and the annuitants toward the FEHBA plan. This will also give other annuitants in such plans an added incentive to enroll in SMI. (This provision was effective 1/2/68.)

SMI TRUST FUND

SMI benefits and administrative costs are paid from the SMI Trust Fund. There are three sources of money for the fund: the monthly premiums paid by the people 65 and over who enroll, a matching amount paid by the general revenue funds of the U.S., and interest on investments held by the fund. Occasionally, for various reasons, the transfer of general revenue funds to the SMI trust fund has not been timely and such delays resulted in a loss of trust fund interest income.

Effective 1/2/68, the law provides that whenever (after 6/30/67) the transfer is not made at the time the enrollee contribution is made, the general revenues will pay, in addition to the Government share, an amount equal to the interest that would have been paid had the transfer been made on time.

In addition, the 1965 law authorized appropriations from general revenues to the SMI trust fund as a contingency reserve until the end of 1967. The reserve was necessary as a safety factor—there was no experience with benefit costs and the reserve accumulated by premium payments and the matching Government contributions would have accumulated only gradually.

The amendments make this contingency reserve available through 1969. During this additional time we will obtain more adequate cost statistics and the "regular" contributions to the trust fund will accumulate for contingencies.